Dartmouth-Hitchcock

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Required Fields*

Microbiology (Routine Culture)

*Patient Full Legal Name (First and Last)

*DH MRN

*Referring Identifier:

Copy To:

*Date of Birth / /

*Collection Date and Time:

*Ordering Provider (print):

*Billing Provider (print):

***Sex**: Female ☐ Male ☐

Patient Type: Inpatient ☐ Outpatient ☐

Location: Skilled Nursing Facility: Yes ☐ No ☐

*PATIENT ID CONFIRMED & SPECIMEN COLLECTED BY - SIGNATURE:

*DIAGNOSIS/Reason for Testing (REQUIRED) / ICD-10:

*BOTH SOURCE AND TEST MUST BE SELECTED

BLOOD

Source	Test
☐ Peripheral (site) ____________	☐ Blood Culture (BD BacTec Set)
	☐ Yeast Culture (Extend 7 days)
☐ Line (site)	☐ Fungus Culture (isolator tube)*
____________	☐ Mycobacteria Culture (MB Bottle)
	☐ Blood Parasite Detection (EDTA)
*contact microbiology for isolator tube	Travel History required:___________
	☐ Other:________________________
☐ Vascular Cath Tip	☐ Aerobic (ID Approval required)
	☐ Yeast Culture
☐ Bone Marrow	☐ Aerobic culture
	☐ Fungus Culture*
*contact microbiology for isolator tube	☐ Mycobacterial Culture

FLUID/WOUND/TISSUE

Source	TEST
☐ CSF(tube2)	☐ Routine Culture/Gram Stain
☐ CSF Shunt/Vent	☐ Anaerobic Culture/Gram Stain
☐ Body Fluid	☐ Fungus Culture
☐ Tissue	☐ Calcofluor stain (not performed on swabs)
☐ Skin Superficial	☐ Mycobacterial Culture/Stain
☐ Aspirate/Wound Abscess-Deep	☐ Cryptococcal AG (CSF only)
	☐ Sonicated Tissue/Implant culture
Specify Source ________________	

GASTROINTESTINAL

Source	TEST
☐ Duodenal Aspirate (send stat)	☐ Enteric Pathogens Culture
☐ Stool	(Para-pak orange required)
☐ Other:________________	includes: Yersinia, E.coli 0157,Salmonella, Shigella
	Campylobacter Antigen & Shiga Toxin Antigen
	☐ Enteric Pathogens,Other (Para-pak orange):
	Specify:________________
	☐ Giardia/Cryptosporidium Screen (parapak)
	☐ Ova and Parasite (parapak)
	Travel history required_________
	☐ Fecal WBC (clean cup)
	☐ C.difficile Screen (clean cup)
	☐ Rotavirus Ag (clean cup)
	☐ H. Pylori Antigen (clean cup)
	☐ Pinworm (Tape prep/paddle)
	☐ Parasite ID (tick, worms)
	☐
	☐

EYE

Source	TEST
☐ Conjunctiva	☐ Aerobic Culture/Gram Stain
☐ Corneal Scraping	☐ Anaerobic Culture/Gram Stain
☐ Vitreous Fluid	☐ Fungus Culture
☐ Other:________________	☐ Calcofluor Stain (send slide)
	☐ Chlamydia Gene amplification
	☐ GC Gene Amplification

URINE

Source	TEST
☐ Clean Voided	☐ Routine Culture (aerobic)
☐ Cystoscopy	☐ Yeast Culture
☐ Indwelling Catheter	☐ Legionella Antigen
☐ Nephrostomy Tube	☐ Chlamydia Gene amplification
☐ Straight Catheter (in/out)	☐ GC Gene Amplification
☐ Other: _______________	☐ Trichomonas Gene Amp
	☐ Mycobacteria Culture
	☐ Other: ________________

LOWER RESPIRATORY

Source	TEST
☐ Sputum, Expectorated	☐ Routine Culture (aerobic) & Gram Stain
☐ Sputum, Induced	☐ Fungus Culture
☐ Bronchoalveolar Lavage	☐ Calcofluor stain (not performed on swabs)
☐ Tracheal Aspirate	☐ Mycobacteria Culture/Stain
☐ Cystic Fibrosis Patient	☐ Mycobacteria Culture/Stain + PCR
specify source_____________	☐ Legionella Culture
☐ Other:_______________	☐ Pneumocystis DFA
	☐ BAL Quantitative culture
VTM= Viral transport media	☐ Chlamydia pneumoniae PCR
	☐ Mycoplasma pneumoniae PCR (VTM)
	☐
	☐

UPPER RESPIRATORY

Source	TEST
☐ Nasopharyngeal Wash	☐ Routine Culture (aerobic) & Gram Stain
☐ Nasopharynx	☐ Anaerobic Culture/Gram Stain (sinus only)
☐ Nasopharyngeal Aspirate	☐ Staph aureus screen culture
☐ Sinus Aspirate	☐ Mycobacterial Culture/Stain
	☐ Fungus Culture
NP= Nasopharyngeal source required	☐ Calcofluor Stain (not performed on swabs)
	☐ Influenza A/B/RSV (NP)
	☐ Full resp. viral panel (16 targets)(NP)
☐ Throat	☐ Group A Strep Antigen
	☐ Strep screen culture
VTM= Viral transport media	☐ Chlamydia Gene Amplification
	☐ GC Gene Amplification
	☐ Ureaplasma PCR (Neonates only)(VTM)
	☐ Yeast Culture
☐ Ear, External Canal	☐ Aerobic Culture/Gram Stain
	☐ Fungus Culture

GENITAL SPECIMENS

Source	TEST
☐ Cervix	☐ Aerobic Culture
☐ Urethra	☐ BV Rapid Test
☐ Vaginal Swab	☐ Yeast Culture
☐ Other:_____________	☐ Group B Strep Culture (vag/rectal only)
	☐ GC Culture (E-swab required)***
	☐ GC Gene Amplification
*****= Pedi medicolegal cases only**	☐ Chlamydia Gene Amplification
	☐ Trichomonas Gene Amplification

REFER TO LABORATORY HANDBOOK FOR ADDITIONAL INFROMATION: https://one-dh.testcatalog.org/

SEND ALL SPECIMENS TO MICROBIOLOGY VIA COURIER OR TUBE STATION
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